COLANTONI COLLINS FOLSOM
LISA HARD
855-396-1220 402
MAIL-SAC@CCMPT.COM

AUG 2 6 2019

PROOF OF SERVICE BY MAIL
JONATHAN SHOCKLEY v. BIOTELEMETRY, INC. dba CARIONET, LLC
(CHUBB INDEMNITY INSURANCE COMPANY)
WCAB NO: ADJ12031731 (OAK)
CLAIM NO: 040519008736

I, Melissa Hard, declare as follows:

I am over the age of 18 years, and not party to this action. My business address is 340 Palladio Parkway, Suite 533, Folsom, CA 95630, which is located in the county where the mailing described took place.

I am readily familiar with the business practice at my place of business for collection and processing of correspondence for mailing with the United States Postal Service. Correspondence so collected and processed is deposited with the United States Postal Service that same day in the ordinary course of business.

On **August 22, 2019**, at my place of business at Folsom, California, a copy of the following documents:

- **ANSWER TO APPLICATION FOR ADJUDICATION OF CLAIM DATED 08/22/2019**

were placed for deposit in the United States Postal Service in a sealed envelope, with postage fully prepaid, addressed to:

ORIGINAL TO (E-FILED):
Workers' Compensation Appeals Board
1515 Clay Street, 6th Floor
Oakland, CA 94612-1519

COPIES TO:
Mario Castro
Chubb Group of Insurance Companies
Western Claim Service Center
PO Box 42065
Phoenix, AZ 85080-2065

///

Farber & Co.
333 Hegenberger Road, Suite 504
Oakland, CA 94621

EDD
PO Box 1857
Oakland, CA 94604-1857

and that envelope was placed for collection and mailing on that date following ordinary business practices.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on **August 22, 2019**.

By: M Hard
Melissa Hard

EAMS Electronic Adjudication Management System

Submission of this eform through EAMS constitutes service upon any internal DWC unit.

Batch ID: 31664318 Date: 08/22/2019 10:39:57 AM

OK

Document Type*: ---select---

Document Title*: ---select---

Document Date: (MM/DD/YYYY)

Author:

File Upload*: Browse...

Attachment

Uploaded Documents

Document Type	Document Title	File Name	
LEGAL DOCS	PROOF OF SERVICE	C:\fakepath\Proof of Service.pdf	Delete

Done

STATE OF CALIFORNIA
DWC DISTRICT OFFICE
E-COVER SHEET

Companion Cases Exist ☐ Location*: CTL

More than 15 Companion Cases ☐ Walk Thru Yes ◯ No ◉

Date: (MM/DD/YYYY) 08/22/2019

Case Number*: ADJ12031731 SSN(Numbers Only)

◯ Specific Injury (If Specific Injury, use the start date as the specific date of injury)

◯ Cumulative Injury (START DATE: MM/DD/YYYY) * (END DATE: MM/DD/YYYY)

Body Part 1 : Body Part 2 :

Body Part 3 : Body Part 4 :

Other Body Parts :

Please check unit to be filed on (check only one box)*

◉ ADJ ◯ DEU ◯ SIF ◯ UEF ◯ SAU ◯ INT ◯ RSU

Companion Cases

Case 1:

◯ Specific Injury (If Specific Injury, use the start date as the specific date of injury)

◯ Cumulative Injury (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

Body Part 1 : Body Part 2 :

Body Part 3 : Body Part 4 :

Other Body Parts :

Case 2:

◯ Specific Injury (If Specific Injury, use the start date as the specific date of injury)

◯ Cumulative Injury (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

Body Part 1 : Body Part 2 :

Body Part 3 : Body Part 4 :

Other Body Parts :

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
ANSWER TO APPLICATION FOR ADJUDICATION OF CLAIM

Case Number:	ADJ12031731

(Choose only one)

☐ a specific injury on _____ (MM/DD/YYYY)

☑ a cumulative trauma injury which began on 06/25/2018 (START DATE: MM/DD/YYYY)

and ended on 02/15/2019 (END DATE: MM/DD/YYYY)

Name(s) of Answering Party(ies): COLANTONI COLLINS SAN FRANCISCO

(Please leave blank spaces between names, numbers or words)

Injured Worker

First Name*	JONATHAN
MI	
Last Name*	SHOCKLEY

Employer Information

◉ Insured ○ Self-Insured ○ Legally Uninsured ○ Uninsured

Employer Name	BIOTELEMETRY INC DBA CARDIONET LLC
Employer Street Address/PO Box	1000 CEDAR HOLLOW RD
City	MALVERN
State	PA
Zip Code (Numbers Only)	19355

Insurance Carrier Information (if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name	CHUBB INDEMNITY INSURANCE COMPANY
Insurance Carrier Street Addr/PO Box	PO BOX 42065
City	PHOENIX
State	AZ
Zip Code (Numbers Only)	85080

Claims Administrator Information (if applicable)

Claims Admin Name	CHUBB GROUP LOS ANGELES
Claims Admin Str Addr/PO Box	PO BOX 42065
City	PHOENIX
State	AZ
Zip Code (Numbers Only)	85080

ANSWERING DEFENDANTS deny the allegations of the application as indicated below with such explanations as expressly set forth and admit all other material allegations.

DENIALS
(Mark X if allegation is denied) **EXPLAIN BELOW**

☐ Employment

Field size limited to 129 characters

☐ Occupation

Field size limited to 129 characters

☒ Injury

BUE ARM WRIST AND HAND ACCEPTED

Field size limited to 85 characters

(IF DENIAL IS BASED ON DATE OR PART OF BODY INJURED, EXPLAIN FULLY)

☒ Insurance Coverage

MAY 31 2016 THROUGH MAY 31 2019

Field size limited to 84 characters

(STATE IF EMPLOYER HAS BEEN NOTIFIED TO APPEAR AND DEFEND)

☒ Liability for self-procured treatment

REASONABLE AND NECESSARY

Field size limited to 129 characters

☒ Liability for future medical treatment

REASONABLE AND NECESSARY

Field size limited to 129 characters

☒ Medical Legal Costs

REASONABLE AND NECESSARY

Field size limited to 129 characters

☒ Earnings

SUBJECT TO PROOF

Field size limited to 129 characters

☒ Periods of Disability

SUBJECT TO PROOF

Field size limited to 84 characters

(GIVE LAST DAY WORKED AND CORRECT DATE OF RETURN TO WORK).

☒ Rehabilitation

SUBJECT TO ELIGIBILITY

Field size limited to 129 characters

☒ Supplemental Job displacement / return to work

SUBJECT TO ELIGIBILITY

Field size limited to 129 characters

☒ Permanent disability

APPORTIONMENT

Field size limited to 126 characters

(IF APPORTIONMENT IS CLAIMED, SO STATE)

IT IS FURTHER ALLEGED

1. Defendants have paid disability indemnity in the total amount of $

at the rate of $

a week beginning MM/DD/YYYY through MM/DD/YYYY

plus

2. Affirmative defenses and other matters : (Field size limited to 448 characters)

ANY AND ALL DEFENSES UNDER THE CALIFORNIA LABOR CODE AND CODE OF REGULATIONS.

The Answer to this Application is being filed on behalf of (Please check one only)

◯ Employer ◯ Insurance Carrier ◉ Both

Defendant(s) do(es) not waive the right to raise additional issues in accordance with the provisions of law and the Rules of Practice and Procedure if other issues develop.

Dated: 08/22/2019

Date (MM/DD/YYYY)

S JAMES GOINES Phone Number 8553961220

Signature

Firm Name	COLANTONI COLLINS SAN FRANCISCO
Address/PO Box	201 SPEAR ST STE 1100
City	SAN FRANCISCO
State	CA
Zip Code (Numbers Only)	94105